General Pharmaceutical Council

# Registered pharmacy inspection report

**Pharmacy Name:** Lakes Pharmacy, 2a China House, 401 Edgware Road, London, NW2 6GY

**Pharmacy reference:** 9012094

**Type of pharmacy:** Internet / distance selling

**Date of inspection:** 05/06/2024

## Pharmacy context

This is a distance-selling pharmacy in a commercial area of northwest London. It dispenses prescriptions for people in care homes. The pharmacy is closed to the general public, so it does not see people face-to-face.

## Overall inspection outcome

✔ **Standards met**

**Required Action:** None

Follow this link to find out what the inspections possible outcomes mean

## Summary of notable practice for each principle

| Principle | Principle finding | Exception standard reference | Notable practice | Why |
|---|---|---|---|---|
| **1. Governance** | Good practice | 1.1 | Good practice | The pharmacy encourages its team members to continually learn from their mistakes and share learnings with the whole team. They agree actions and devise new ways of working to make the pharmacy's services safer. |
| | | 1.2 | Good practice | Members of the team are encouraged and supported to introduce ways of monitoring services and improving safety. |
| | | 1.3 | Good practice | The team members understand their roles and responsibilities within each part of the pharmacy team. And there are clear audit trails identifying who completed each part of a process. |
| **2. Staff** | Good practice | 2.1 | Good practice | Team members' workloads are reviewed and re-allocated to increase the efficiency of the team and complete tasks in a timely manner.. |
| | | 2.2 | Good practice | The pharmacy supports and encourages team members to undertake learning and development relevant to their roles. |
| | | 2.3 | Good practice | There is active engagement with staff to proactively share ideas and identify any concerns. |
| **3. Premises** | Standards met | N/A | N/A | N/A |
| **4. Services, including medicines management** | Good practice | 4.2 | Good practice | The pharmacy maintains robust audit trails identifying team members who provide the services. And it manages the delivery service well so care homes receive their medicines safely on time. |
| | | 4.3 | Good practice | The pharmacy manages its medicines stock well. It keeps records to show pharmacy stock is checked regularly, stored securely at the right temperature and safe to use. |
| **5. Equipment and facilities** | Standards met | N/A | N/A | N/A |

## Principle 1 - Governance ✔ Good practice

### Summary findings

The pharmacy's working practices are safe and effective. It has systems in place for team members to continually learn from their mistakes, take action to prevent them happening again and share learnings with the whole team. Members of the team are encouraged to introduce ways of monitoring and improving safety. The pharmacy has suitable standard operating procedures in place which the team follow to manage the risks associated with providing services. It actively asks people who use the pharmacy for feedback. The pharmacy keeps the records required by law showing it supplies its medicines and services safely. Members of the pharmacy team protect people's private information, and they are trained in how to safeguard the welfare of vulnerable people.

### Inspector's evidence

The pharmacy had a number of systems to review dispensing errors and near misses. Members of the pharmacy team recorded their mistakes on the pharmacy computer system and depending on the type of error, they were awarded a yellow or red card. Red cards represented mistakes with controlled drugs (CDs) and yellow cards represented non-CD mistakes. Team members attended a weekly meeting and were encouraged to discuss the mistakes they made to spot patterns to learn from them and agree actions to reduce the chances of them happening again. The pharmacist produced a weekly summary or patient safety review (PSR) which was sent to each team member. A member of the team explained that medicines involved in incidents, or were similar in some way, were generally separated from each other in the dispensary. Lookalike and soundalike (LASA) medicines were highlighted at the weekly meeting. And there were clear Perspex dividers in places on the dispensary shelves which kept medicine packs in the correct slots preventing them becoming mixed up with other medicines. This helped reduce picking errors.

The care homes requested the prescriptions and sent a copy of what had been requested to the pharmacy so it could check for changes and missing medicines. A separate team which included a dispensing assistant, downloaded the electronic prescribing system (EPS) prescriptions. A member of the team had created a 'weekly mistakes' form to collate any errors associated with downloaded prescriptions. And information on error types such as quantity errors, dosage errors and wrong items could be captured and analysed. Team members screened the prescriptions and emailed the prescribers regarding issues with new medicines, interactions with other medicines and unusual doses. Labels were generated and prescriptions were dispensed once the prescriber responded and the issue was resolved. Email responses were attached to the person's patient medication record (PMR) forming an audit trail. A member of the team explained that the pharmacy rarely accessed national care record service (NCRS).

Members of the pharmacy team responsible for making up people's prescriptions used colour-coded baskets to separate each person's medication and to help them prioritise their workload. They worked to a colour-coded matrix to make sure prescriptions were processed one week, dispensed the next week and delivered the week after. They referred to prescriptions when labelling and picking products. And assembled prescriptions were not bagged and packed into tote boxes until they were clinically and final checked by the pharmacist. The team stamped the prescription to show the number of items, ticked and re-ticked each item as it was picked, labelled and checked. Team members were allocated a

number which they used to endorse the prescription producing an audit trail so it was easy to identify who had completed each step of the dispensing process. The pharmacy had worked out the number of prescriptions which a team member could realistically dispense each day and this helped with allocation of tasks, time management and delivering of medicines in a timely manner.

The pharmacy did not part-supply any medicines as there was enough time built into the systems to download and process prescriptions, order medicines and label them before dispatch. If there was a supply issue the pharmacy emailed the prescriber to arrange an alternative medicine. And the team monitored missing items from prescriptions. The pharmacy emailed the care home regarding information about discharge from hospital, allergies and delivery of the medicines. It created a medicines administration record (MAR) chart for each medicine supplied. The pharmacy team sent the care home guidance on medicines to be administered to people via covert administration. If the formulation was unsuitable for covert administration, it asked the prescriber to prescribe an alternative equivalent medicine which was suitable for mixing with a food item prior to giving it to the person. The required documentation authorising medicines to be administered covertly was signed by the person's doctor, next of kin and the pharmacy.

The pharmacy supplied the majority of prescribed medicines in the original manufacturer's packaging. A small number of people were supplied with multi-compartment compliance packs or a blister card which was 'racked'. The pharmacy team attached a piece of the original pack showing the medicine's name and strength along with the batch number and expiry date to the reverse side of the blister card. Apart from the dispensing label this acted as an extra check of the medicine which was enclosed in the blister card. The pharmacy team member described a documented business continuity plan to make sure people would receive their medicines following an adverse event. The pharmacy had risk assessed managing how vulnerable pharmacy team members dispense some high-risk medicines and how team members managed manual lifting. The pharmacy had completed audits such as the anti-coagulant, asthma and antibiotics for the pharmacy quality scheme (PQS). And it had undertaken a clinical audit of people who were prescribed a valproate and the new rules for supplying a valproate.

The pharmacy had standard operating procedures (SOPs) for the services it provided. And these had been reviewed by the superintendent pharmacist (SI). The SOPs included responsible pharmacist (RP) procedures, complaints and delivery and were endorsed with review dates. Members of the pharmacy team were required to read and sign the SOPs relevant to their roles to show they understood them and would follow them. New team members trained in the SOPs and ensuring all the team members re-read SOPs after a review was discussed in case there were any changes in procedure to implement. And the pharmacy had a locum guide for reference.

The pharmacy displayed a notice that told people who the RP was and it kept a record to show which pharmacist was the RP and when. Members of the pharmacy team knew what they could and could not do, what they were responsible for and when they might seek help. And their roles and responsibilities were described within the SOPs. The pharmacy asked people who visited the pharmacy or used its services for their views and suggestions on how it could do things better. A member of the team described acting on feedback regarding medicines storage. Representatives of the pharmacy had regular meetings with the care homes where feedback was exchanged between both parties.

The pharmacy had appropriate insurance arrangements in place, including professional indemnity, for the services it provided. The pharmacy had an electronic controlled drug (CD) register which was password protected. And the stock levels recorded in the CD register were checked regularly. A random check of the actual stock of a CD matched the recorded amount in the register. The pharmacy kept records for the supplies of the unlicensed medicinal products it made which a member of the pharmacy team explained. The pharmacy did not make emergency supplies of medicines or dispense private

prescriptions. The pharmacy backed up the PMR regularly where it maintained patient records including interventions. It recorded patient consent for consultations and Patient Access. The pharmacy was signed up to PharmOutcomes in case of having to access referrals such as discharge summaries from hospitals.

The pharmacy was registered with the Information Commissioner's Office. The pharmacy team had trained in information governance, signed confidentiality clauses, and the pharmacy computer was password protected. The pharmacy displayed a notice that told people how their personal information was gathered, used and shared by the pharmacy and its team. Team members made sure people's personal information was disposed of securely. They stored their NHS Smartcards safely when they were not in use. The pharmacy had a safeguarding SOP. And the pharmacists had completed a level 3 safeguarding training course. Members of the pharmacy team knew what to do or who they would make aware if they had concerns about the safety of a vulnerable person.

## Principle 2 - Staffing ✔ Good practice

### Summary findings

The pharmacy has enough team members who are qualified or training to have the appropriate skills and qualifications for their roles. Members of the team work effectively together in a supportive environment. The pharmacy reviews the workload to increase the efficiency of the team. The pharmacy team can provide feedback which is acted upon. And they know how to raise concerns relating to the pharmacy's services.

### Inspector's evidence

The pharmacy team comprised four pharmacists, part or full-time and one of whom was training as an independent prescriber, twelve full-time trainee or qualified dispensing assistants, a full-time administrative team with six team members and one dispensing assistant, two full-time team members to pack medicines once they had been checked, one part-time team member to unpack and check the order and two delivery drivers who had completed accredited training and were Disclosure and Barring Service (DBS) checked.

The pharmacy always had two pharmacists on duty to manage the workload and to be able to overlap duties. The dispensing assistant on the administrative team contacted and liaised with prescribers and the care homes when issues arose. At the time of the visit, a locum dispensing assistant was in the process of tidying all the pharmacy medicines stock, checking expiry dates of medicines and monitoring split packs of tablets and capsules.
Members of the pharmacy team were enrolled on or had completed accredited training relevant to their roles. They worked well together, following the pharmacy’s procedures so prescriptions were processed safely. And each team member completed the audit trail identifying who was involved at each stage of preparing each prescription.

The pharmacy supported team members with training to progress their roles and by allocating protected learning time if needed. For instance, accuracy checking technician (ACT) training was available. The team had undertaken training in topics required by the pharmacy quality scheme (PQS) such as safeguarding, sepsis and risk assessment. The pharmacy maintained a record of qualifications and planned training for the team members. They went to the annual pharmacy show and attended the continuing professional development meetings. Their progress and training needs were monitored twice a year. The team had a WhatsApp group for urgent communications and to circulate the weekly summary or patient safety review (PSR) to each team member.

Team members had weekly meetings where they could voice feedback and make suggestions either in person or via a suggestions box. The pharmacy agreed to ‘pizza/pastry Thursday’ and a coffee machine suggested by team members. The pharmacy encouraged team spirit with regular pizza and darts events. And there was an attractive clean, bright space equipped with a coffee machine and microwave where team members could eat during their breaks. They were comfortable about making suggestions on how to improve the pharmacy and its services. They knew who they should raise a concern with if they had one.

## Principle 3 - Premises ✔ Standards met

### Summary findings

The pharmacy's premises are clean, bright, secure and suitable for the provision of healthcare services. The pharmacy prevents people accessing its premises when it is closed so its medicines stock is safe, and people's private information is protected.

### Inspector's evidence

The registered pharmacy premises were bright, clean and secure. And steps were taken to make sure the pharmacy and its team did not get too warm. The pharmacy was spacious and fitted out with shelving units to accommodate the pharmacy’s medicines stock and workbenches where team members prepared prescriptions. The pharmacy did have a consulting room although it was not in use because there was no face-to-face contact with people who used the pharmacy. The pharmacy was cleaned three times a week.

## Principle 4 - Services ✔ Good practice

### Summary findings

The pharmacy is an internet pharmacy so it does not see people who use its services face to face. It is good at providing its services safely and the pharmacy team can demonstrate how they manage their workstreams to ensure efficiency and effectiveness. The pharmacy team maintain thorough audit trails identifying each team member involved in providing the service. The pharmacy obtains its medicines from reputable sources and stores them securely at the right temperature so that they are fit for purpose and safe for people to use. People taking higher-risk medicines are provided with the information they need to use their medicines properly. The pharmacy takes the right action in response to safety alerts so that people get medicines and medical devices that are safe to use.

### Inspector's evidence

The pharmacy's entrance was level with the outside pavement. This made it easier for people who used a wheelchair, to enter the building. The pharmacy's opening hours were on its website along with other information about its services. Members of the pharmacy team were helpful and could speak or understand languages including Mexican, Romanian and Portuguese. They signposted people to another provider if a service was not available at the pharmacy. The pharmacy was signed up to provide the NHS Pharmacy First service although it had received a low level of referrals to date. The pharmacy was generally contacted directly by the hospital when people were discharged from hospital.

The pharmacy provided a delivery service as people did not attend its premises in person. It emailed the care home the day before the delivery with all the delivery details. All the medicines to be delivered were placed in one part of the pharmacy and arranged so everything for one care home was together in tote boxes, listed and then photographed. The pharmacy delivered medicines to a few care homes at a time. And medicines requiring refrigeration were packed with icepacks. Upon arrival at a care home, the nurse on duty checked off the delivery and returned the completed delivery sheet to the delivery person for the pharmacy to retain against any queries . The pharmacy computer system printed barcodes on labels which were scanned to form an audit trail as medicines were scanned out of the pharmacy for delivery to a home.

The pharmacy supplied the majority of medicines in their original manufacturer's packaging which meant that tablets and capsules did not have to be popped out of their blisters to be repackaged in multi-compartment compliance packs. This was more hygienic and cut down on process and packaging waste. The care homes ordered their own prescriptions and sent a copy of the order to the pharmacy to reconcile with the prescriptions which were received. The pharmacy had a business continuity plan to ensure there would be little disruption to services in the event of an unforeseen event. The team would alert a nearby pharmacy and redirect EPS prescriptions. The pharmacy recorded counselling notes on MAR charts. And supplied warning cards for high-risk medicines such as warfarin or methotrexate. It highlighted high-risk medicines with warning stickers. Pharmacy team members were aware of recent changes in rules for supplying a valproate.

The pharmacy supplied medicines in a disposable multi-compartment compliance pack for a small number of people. The pharmacy team checked whether a medicine was suitable to be re-packaged, provided a brief description of the medicines contained in the compliance packs and provided patient

information leaflets. So, people had the information they needed to make sure they took their medicines safely. The pharmacy maintained audit trails so it could identify team members involved and track prescriptions requested, downloaded, dispensed and delivered. The pharmacy planned the work pattern to manage the workload so it was completed within a given time. The dispensers were each allocated a number which they endorsed the prescriptions with and each part of the process was ticked as it was completed.

The pharmacy used recognised wholesalers to obtain its pharmaceutical stock. On receipt of the order, medicines were unpacked and checked off in a dedicated area of the pharmacy. The pharmacy kept its medicines and medical devices in their original manufacturer's packaging. And marked liquid medicines with a date of opening. The pharmacy team checked the expiry dates of medicines regularly and recorded when this was done. The pharmacy stored its stock A-Z by generic name. The pharmacy stored its stock, which needed to be refrigerated, between two and eight degrees Celsius. And it stored its CDs securely in line with safe custody requirements. During the visit, a locum dispenser was observed tidying stock and removing split packs from the whole packs of medicines on the shelves. A member of the team explained that the pharmacy employed a locum dispenser to undertake this stock management task form time to time and it would take approximately two weeks to complete.

The pharmacy had procedures for handling its own date-expired medicines but signposted the care homes to a website where they could arrange for disposal of the care home's unwanted medicines. The pharmacy's unwanted medicines were kept separate from stock. The pharmacy had a procedure for dealing with alerts and recalls about medicines and medical devices. And a pharmacy team member described the actions they took and what records they kept when the pharmacy received a concern about a product. Sometimes the pharmacy team had to contact the care homes to trace affected batches of a medicine supplied prior to receiving the alert such as one concerning salbutamol nebules.

## Principle 5 - Equipment and facilities ✔ Standards met

### Summary findings

The pharmacy has the equipment and facilities it needs for the services it offers. The pharmacy uses its equipment appropriately and keeps people's private information safe.

### Inspector's evidence

The pharmacy team had access to online up-to-date reference sources. The pharmacy had several fridges to store pharmaceutical stock and prescriptions awaiting dispatch requiring refrigeration. And its team regularly checked and recorded the maximum and minimum temperatures of each refrigerator. The pharmacy collected confidential wastepaper for secure disposal. The pharmacy restricted access to its computers and PMR system. And only authorised team members could use them when they entered their password. The pharmacy positioned its computer screens so they could only be seen by a member of the pharmacy team. And its team members made sure their NHS smartcards were stored securely when they were not working.

## What do the summary findings for each principle mean?

| Finding | Meaning |
|---|---|
| ✔ Excellent practice | The pharmacy demonstrates innovation in the way it delivers pharmacy services which benefit the health needs of the local community, as well as performing well against the standards. |
| ✔ Good practice | The pharmacy performs well against most of the standards and can demonstrate positive outcomes for patients from the way it delivers pharmacy services. |
| ✔ Standards met | The pharmacy meets all the standards. |
| Standards not all met | The pharmacy has not met one or more standards. |